## Chapter 1: CARES

### Continuing VA's Improvement Process

CARES is a systematic planning process to prepare VA's facilities and campuses to meet the future veterans health care needs through a methodical, system-wide assessment of the current existing and future needs for space, and of the size, mission and locations of facilities, compared to the number of projected enrollees and forecasts of their anticipated utilization of medical services. The changes described will occur over an extended period. In particular, the complexity of realigning clinical services and campuses necessitate careful planning in order to ensure a seamless transition in services. The Draft National CARES Plan contains the capital requirements to enhance the current infrastructure so that VA health care services are delivered in a modern functional health care environment. CARES is another step in the dynamic improvement process that characterizes the VA health care system. The CARES process follows the many improvements achieved in the processes and outcomes by the VA.

Quality is an essential component in any assessment. A recent judgment presented in an authoritative medical journal provided a definitive indication of how VA care compares with the medical community at large. Simply stated, VA care was found to be significantly better than care provided in the fee-for-service program paid for through Medicare. This conclusion was reported in a study published in the *New England Journal of Medicine,* which compared VA care with the Medicare fee-for-service program on 11 similar quality indicators for the period from 1997 to 1999. VA scores were better in all 11 categories. The study noted that VA outperformed Medicare again in 2000, this time on 12 of 13 indicators.[1] Calling the study's findings "robust," a *Journal* editorial confirmed, "VA care appears to be better."[2]

Along the way to achieving high scores in quality, the VA established a position of health care industry leadership in patient safety and electronic medical records. In 2002, for example, two VA facilities received the first John M. Eisenberg Patient Safety Awards, sponsored by the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations.[3] And VA's electronic medical record system and Bar Code Medication Administration (BCMA) program have been widely recognized as groundbreaking tools for improving health care quality and patient safety. The BCMA program won the 2002 Pinnacle Award, a top honor presented by the American Pharmaceutical Association Foundation.

Today, numerous other innovative management practices sustain the pace of VA clinical improvements, including:

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[1] NEJM, Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care, Ashish Jha, Vol. 348:2218-2227, May 29, 2003

[2] NEJM, Editorial: The Right Care, Stephen Jencks, M.D., Vol. 348:2218-2227, May 29, 2003

[3] Modern Healthcare, The Week in Healthcare, VA Captures Two Awards, Eisenbergs Reward Patient Safety, Sept. 16, 2002

- Preventive measures such as pneumococal vaccinations and diabetic foot examinations, which demonstrably reduced the incidence of illness and infection in VA's patient population.

- A morbidity and mortality monitoring system, which ensures that quality improvement in VA surgical programs is ongoing.

- Telemedicine initiatives, which not only bring diagnostic support and specialist consultation to remote delivery sites, but allow monitoring of patients in their own homes, in a new "Telehealth care" program.

All of these actions were stimulated and supported through a continuous improvement philosophy instilled throughout the organization, based on the principles of the Malcolm Baldrige National Quality Award.

The most significant element of VA's management re-invention – one which directly facilitated and accelerated positive change in the system – was the creation of decentralized health care delivery systems called Veterans Integrated Service Networks (VISNs). Networks implemented challenging system alterations, such as dramatic reductions in inpatient hospital beds, closures of redundant campuses, and consolidation of services. Under VISN management, the transformed VA system achieved extensive improvements in access and enrolled millions of new veterans (a measure of success which, nonetheless, has put new strains on VA's capital assets). These changes must be incorporated into CARES planning as well as future challenges to be anticipated in the planning for capital assets.

Clearly, the systematic assessment and improvement of quality that has characterized the VA health care system since the early 1990's has produced dramatic results. VHA's determination to emulate this success in the systematic planning for capital assets had an excellent starting place in the CARES process.

The timing for improved capital asset planning is right. The forecasted decrease in the veteran population, though offset in part by increasing numbers of enrollees and aging of the veteran population, is raising questions regarding the size and distribution of VA facilities and outpatient services. VHA planners and leaders must assure that facilities are in the right place and have the physical plant necessary to provide quality care to the aging veteran population. The CARES planning process and the National CARES Plan will prepare VHA to meet that challenges of the provision of veterans' health care in the 21$^{st}$ century.

**What Did CARES Assess?**

CARES focused on capital requirements at a macro level by using projections of beds and outpatient visits by broad categories such as inpatient medicine, surgery and psychiatry, and outpatient primary care, mental health and specialty care. CARES did not develop plans at the diagnostic or service line level (cardiovascular disease,

diabetes, etc.) These lower level plans will be considered as part of VHA's revised strategic planning process.

The CARES process systematically assessed the critical components that determine the future need for capital and services. CARES comprised the first detailed system-wide assessment and integration of the following elements:

- Physical Plant – CARES developed and used assessments of the current condition and functionality of all space that provides and supports the delivery of health care services. A comprehensive evaluation and database were developed to determine the amount of space that did not meet current standards and that should be improved.
- Enrollment – CARES utilized enrollment forecasts by priority group, based upon the Secretary's enrollment decisions and Presidential budget requests.
- Utilization – CARES developed the expected utilization of enrollees for bed days of care and outpatient visits for all priority groups by age and gender, and the specific needs of the SCI and Blind Rehabilitation Program.
- Management of Utilization – CARES prompted VISN decisions on managing utilization changes from a range of alternatives, such as new construction, renovations, leases, contracts and other mechanisms.
- Vacant Space – CARES brought about the evaluation of all vacant space, including determination of potential use in meeting future expected utilization, and all possible disposition alternatives including lease, building demolition, and other divestiture measures.
- Realignments – CARES facilitated a systematic assessment of the potential for realignment of services and campuses. The capital costs and savings of these realignments are not yet fully integrated into the National CARES Plan because their complexity requires more detailed analysis (in the event they are approved.)
- Access – CARES determined driving times to primary outpatient and acute inpatient care, based upon the current locations of VA sites of care, to gauge the percentage and number of veterans who are within travel time guidelines.
- Collaborations – CARES identified opportunities to jointly meet VBA, NCA and DoD needs for space, and the information regarding potential collaborations will be integrated into future assessments of space needs at VHA delivery sites.

**CARES Strategic Emphasis**

The VA health care delivery system of the future requires a capital investment strategy, which is based upon a systematic assessment of the future needs of veterans and the present location and condition of the physical plant that delivers these services to veterans. Because of the dynamic nature of health care delivery in the 21st century, VA's planning tools must be flexible enough to accommodate changes in the projected veterans' health care needs, in medical technology, and in departmental policy. Thus, the National CARES Plan must be seen as a beginning, linked to redesigned strategic planning and a capital asset prioritization process.

## Balancing the System

Outpatient Care

The National CARES Plan must ensure that VA is a balanced health care system that has adequate acute inpatient capacity to meet the acute care needs of an aging veteran enrollee population. The inpatient-oriented approach of the 1980's has been replaced by a system with a strong outpatient orientation, as demonstrated by expansion to more than 600 Community Based Outpatient Clinics (CBOCs), and an increase of 14.5 million annual outpatient visits from 1997 through 2002. A "snapshot" picture of the result may be seen in the fact that, in 2001, VA provided accessible primary care to 67% of enrollees who live within 30 minutes driving time of a primary care delivery site.

The CARES forecasting model projected continued growth in outpatient care, and VISN market plans proposed 234 CBOCs to meet that strategic need. In order to achieve a functional balance between acute care and outpatient services, the National CARES Plan recognized a fundamental tenet of modern health care – i.e., that outpatient demand must be supported by a viable acute and tertiary care component. Achieving this balance is particularly important to VA with respect to the acute and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury.

The National CARES Plan reinforced VA's strategy of ensuring that continued growth in outpatient care would be supported by a high quality, appropriately sized and appropriately located acute care inpatient system. In order to move in the direction of a more balanced system, the National CARES Plan identified the capital requirements needed to expand to meet the growing forecasted demand for outpatient services. Improvements in access to outpatient care (which experience indicates will increase demand) must be balanced against strengthening the inpatient acute infrastructure in order to provide high quality services across the continuum of care.

The investment strategy for outpatient access sites is described in greater detail in Chapter 4. The Draft National CARES Plan proposed a system-wide consideration of potential new access points or CBOCs and a selective process for identifying markets in the plan with new CBOC access sites to be prioritized for early implementation. The highest priority markets are those having predictions of large future demand gaps (by clinic visits), co-existing with large access gaps (by driving time), and also where the number of enrollees per proposed CBOC that fell outside access guidelines met efficiency standards (developed in the review process – i.e., greater than 7,000 enrollees). The second priority group is comprised of markets where large demand gaps co-exist with large access gaps, but the number of enrollees would not meet efficiency standards. The third group consists of CBOCs proposed in markets where there are demand gaps but not access gaps.

The highest priority group also includes CBOCs that are part of the realignment proposals and DoD collaborations. Proposed CBOCs identified through the CARES process in the draft National Plan will also go through a well-developed review process prior to any implementation.

Acute Inpatient Care

As a systematic planning process, CARES, with some campus and service realignments exceptions[2], validated that the current size and location of the acute inpatient care infrastructure will be to meet the future inpatient needs of veterans. The process forecasted that the future demand for acute beds would be largely in balance with current capabilities. Nevertheless, CARES also demonstrated that substantial investment of capital is required to maintain that acute infrastructure to meet the current and future specialized acute and tertiary needs of veterans.

Realignments/Efficient Utilization of Campuses for Veterans Services

The dramatic changes in health care delivery within the United States and the VA include improved methods of treating patients that have reduced lengths of stay and admissions as outpatient, community and home care replace inpatient care. As a result, many campuses have vacant space that is costly to maintain as described elsewhere in the plan. These changes, combined with an aged infrastructure (50.4 years average age of VA facilities) resulted in opportunities for reviewing the structure of our campuses to develop a more efficient footprint, possibly transfer services to other campuses and find opportunities to enhance use lease all or portions of campuses with services for veterans such as assisted living facilities. Revenues from these enhanced uses would be retained by the VISNs to invest in improved services for veterans.

**Use of the National CARES Plan**

Perhaps the most important use of the CARES Plan is a publicly available assessment of capital needs, based on assumptions, policies and methodologies that are open to discussion, systematic improvement, and change over time.

In a system as large as the VA, conducting a comprehensive assessment of current and future capital requirements poses an inherent risk of creating an unmanageable pool of funding requirements. However, a comprehensive assessment is necessary to determine the magnitude of the funding required to fully prepare for the future. While CARES included a comprehensive capital needs assessment of VA's acute infrastructure and existing outpatient sites, the plan recognizes that specific priorities and availability of funds will determine what is ultimately implemented. Of significance in the present context, the National CARES Plan should be viewed as not merely a set of stand-alone funding requirements, but rather as a strategic guide to the future investment of capital, intended to:

- Establish the need for capital requirements, similar to a Certificate of Need in state health care regulatory programs, which – in the case of CARES – reflect

[2] Described in subsequent chapters (see especially Chapters 8 and 9).

the priorities of the Under Secretary for Health and the Secretary of Veterans Affairs;

- Identify realignments of services and campuses that will improve quality and efficiency;

- Provide a 5-year estimate of the capital required to meet all the needs identified; and

- Identify collaborations within VA and with DoD that will result in more efficient use of capital resources.

**The Economics of CARES**

CARES is a systematic process for determining the resources required to meet expected demand for VHA services over the next 20 years. The National CARES Plan reflects thousands of micro decisions made regarding how each VISN would address gaps in forecasted supply and demand for the CARES categories of health care services. Based upon the CARES forecasting planning model and using the computerized Market Planning Template[3], VISNs were able to develop planning scenarios and methodically determine costs of alternatives to manage workload changes or maintain current capacity as determined by the workload forecasts. Decisions whether to renovate, lease, build, or contract were facilitated for all CARES planning categories by using the Market Planning Template.

The CARES process required assessment of the quality of all existing space in use within the VHA – a monumental task in itself. The decisions (and costs) for acquiring additional space *vs*. renovating existing space were analyzed with the operating costs necessary to meet future patient services.

The use of standardized methods allowed many cost alternatives to be assessed in determining how to meet future demands. For example, the costs of contracts could be compared with using in-house resources. In addition, initial estimates of future revenues expected from enhanced use and other revenue generating solutions were identified.

Thus, CARES is multifaceted and no single dollar figure can be placed on all aspects of the process. Depending upon the specific financial aspect being considered, there are several ways of viewing the economics of CARES, as illustrated by the following observations:

<u>Cost Minimization</u>

A distinguishing characteristic of the proposals to address predicated gaps in clinical capacity and of any capital proposal valued at more than $2,000,000 dollars was that VISNs were required to consider alternative solutions. Comparative costs between

[3] Described in Chapter 2.

ways to manage workload forecasts received strong consideration in selecting the preferred solution. However, other CARES criteria such as quality, and potential impact on DoD sharing and academic affiliations also were considered. In the Draft National CARES Plan, the lower cost alternative was selected in nearly 60% of all planning solutions. Improvements in the costing model may increase this percentage when the final National CARES Plan is completed.

Budget

A summary of budget implications of meeting capital costs for the expected workload demand projected in CARES is presented below. The estimates do not include any of the costs, savings, and revenue estimate from the realignment and consolidation of services discussed in Chapters 8 and 9 (Small Facilities and Realignment), except where they were part of the VISN proposed market plans and were included in the market plan template. In most cases, the estimated costs and savings were not included, but will be further developed prior to and during implementation.

Table 1.1 shows the current dollar cost estimates for the five-year budget cycle. These costs include all CARES categories except Research and Other Space. While all the costs represented in Table 1.1 must be refined through specific project applications and further costing to include capital costs and savings from realignments, they do provide an estimate of the magnitude of investment required to maintain and prepare the VHA capital infrastructure for the future.

**Table 1.1. Estimated 5-Year Capital Budget (In Current Dollars) FY 2004 – FY 2008**

| Fiscal Year | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Capital Estimates* | $921,356,849 | $824,137,915 | $743,161,421 | $652,717,033 | $455,889,005 |
| Efficiency Savings Estimates** | $157,137,865 | $202,516,767 | $233,910,786 | $241,083,813 | $287,966,010 |
| Revenue Estimates*** | $27,955,741 | $31,930,287 | $65,059,026 | $68,245,255 | $70,579,766 |
| **Total Cost Estimates** | **$736,263,243** | **$589,690,862** | **$444,191,609** | **$343,387,966** | **$97,343,228** |

* Capital Investment Costs include all proposed construction, demolition and build-out costs for new leases. The capital estimates do not include recurring lease costs. They do not yet include capital costs of savings associated with the realignment or consolidation of services that are in the Draft National CARES Plan but require further cost analysis before inclusion in the final Plan.

** Efficiency Savings include such things as savings in utility or maintenance costs from demolishing buildings or consolidation of services. These costs were estimated by VISNs. However, they did not have a standardized way to estimate these savings so this dollar figure is not a comprehensive estimate. These savings will be more fully developed during implementation.

*** Revenues were also estimated by the VISNs and are not comprehensive. Examples of revenues include estimates from Enhanced Use Lease initiatives or revenues from the sale of property. These estimates will also be more fully developed during implementation.

All Capital Investments

Capital investments for the 20-year planning period are estimated at $4,655,503,656 (in current dollars) plus $468,555,970 proposed for Research. Capital investment needs and estimates beyond the five-year period used in the budget estimates above are not as reliable as the 5-year budget period due the inherent difficulty of capital planning beyond a 5-year period. Capital Investment needs will be dictated by changing health care delivery practices and changes in technology. Although the amount of space required for future needs can be estimated using the workload projections, other capital needs cannot be identified beyond five years with the same degree of accuracy. The forecasting results will be reconsidered each year in the VHA planning cycle in order to ensure that the capital forecasts reflect changing policy, technology and other dynamics within the health care system.

Vacant/Underutilized Space

- The National CARES Plan would achieve a 42% reduction in vacant/underutilized space nationally, from 8,571,605 square feet in FY 2001 to 4,934,002 square feet in FY 2022.

- Savings from reducing vacant/underutilized space would total over $45 million per year. [Note that the GAO report which estimated a savings of $1 million a day was based on **complete** campus closures (about 19-20 campuses) and not individual building closures, so it not comparable to this CARES study.]

- Total demolition costs would amount to $58,796,952.

Service Consolidations (Proximity) and Campus Realignments

Actual savings due to campus realignments, consolidations, downsizing and closures will be assessed in detail during the CARES implementation process. When the proposed realignments and consolidations are approved as strategic directions, final decisions regarding relative savings and costs of the changes will be fully analyzed before the implementation plan is finalized.

**Implementation of the National CARES Plan**

Implementation of the National CARES Plan will extend over many years. It will be multifaceted, depending upon whether implementation requires additional capital, recurring funding, primarily policy changes and/or realignments that are possible at minimal cost. For example, converting to a Critical Access Hospital[4] is driven more by policy than by resources, whereas meeting the requirements to upgrade the acute capital infrastructures are heavily dependent on budget. Priority mechanisms, either in place or recently revised (such as the Capital Asset Prioritization process), will advance funding proposals from the National CARES Plan on a project-by-project basis.

[4] See Chapter 8, Small Facilities.

Extensive development of business plans, clinical service consolidation plans, contracting and other plans will require time to ensure that services are maintained to veterans during the transition period.

The National CARES Plan also proposed additional collaborations within VA – with VBA and NCA – to maximize the use VA assets. These implementation plans will fall under the "One VA" Initiative managed by the VA. Numerous additional collaborations between VA and DoD sites will ensure the most effective use of federal health care assets and will be integrated within the VA/DoD collaborative mechanisms currently in place.

The community is an important partner in the implementation process. Partnerships with the community, in which community resources can be used to meet VA capital requirements, are proposed in the plan. Community contracts are an effective way to meet changes in demand that warrant investments in capital. They also often bring services closer to veterans, particularly in rural areas. They are particularly encouraged in the context of the demand peak in 2012 and 2013. Innovative approaches to community partnerships will be encouraged for further development during implementation.

**Cycles of Improvement**

CARES was the first step in VHA's revised strategic planning process. The planning horizon extends to 2022, and the plan is based upon enrollment and utilization forecasts. As in all strategic plans that look into the future based upon assumptions, policies, health care delivery and veteran choices, the planning system must be sufficiently flexible to adapt to a changing health care environment. The forecasts and forecasting methods will be continuously tested and improved by monitoring actual experience. In addition, alternative future scenarios may be created to ensure that investments that are planned remain viable as developments pose new challenges and opportunities. Until fully implemented, all approved CARES proposals will be updated based upon the latest forecasts of veteran enrollee workload.